

This publication was developed by the U.S. Department of Housing and Urban Development to assist in the planning and development of Neighborhood Networks centers.

The guides in this series offer "how to" information on starting up a center, creating programs and identifying center partners; center and program profiles and a wealth of resources.

Neighborhood Networks is a community-based initiative established by the U.S. Department of Housing and Urban Development (HUD) in 1995. Since then, hundreds of centers have opened throughout the United States. These centers provide residents of HUD-assisted and/or -insured properties with programs, activities and training promoting economic self-sufficiency. These guides contain examples of successful center initiatives and how you can replicate them.

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TO GOOD HEALTH!
A GUIDE TO PROVIDING HEALTH CARE AT
NEIGHBORHOOD NETWORKS CENTERS
JUNE 1999

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To Good Health!

A Guide to Providing Health Care at Neighborhood Networks Centers

Introduction

In the changing health care environment, access to care for people with lower incomes remains an issue. Some people do not qualify for Medicaid; others may qualify but have not accessed the system. Still other people live in communities where medical services are scarce or there is no access to them. Sometimes transportation is the barrier, sometimes it's childcare.

The programs described in this guide demonstrate how six models have met the health care needs of low-income people by providing programs and services designed to meet their specific needs. These programs are models that Neighborhood Networks centers can apply as they offer health care services.

Neighborhood Networks is a community-based initiative launched by the U.S. Department of Housing and Urban Development's (HUD) Office of Multifamily Housing in September 1995. This initiative encourages the development of resource and computer learning centers in HUD-assisted and/or -insured properties.

The guide begins with a discussion of why Neighborhood Networks centers may wish to incorporate health care programs into their activities. An explanation follows of the criteria used to select the case studies that are described in Chapter 2. Chapter 3 provides strategies for implementing programs. Finally, useful resources for starting up a program are identified in Chapter 4.

Chapter 1

Why Should A Neighborhood Networks Center Have A Health Care Component?

Good health is at the root of one's ability to learn, parent and work.

The goal of the Neighborhood Networks initiative is to build self-reliant communities by bringing technology and other resources to HUD-assisted and/or -insured housing. Computer access and training, job readiness support and literacy classes will improve prospects for employability for residents.

However, without addressing health care, transitioning people from welfare to work will likely fail. Access to quality health care is important for seniors living in assisted housing, too. Seniors make up 47 percent of the households in privately-owned project-based Section 8-assisted and -insured properties and for many of them, independent living requires supportive services. It has been well documented that greater access to health care reduces the number of times an individual is hospitalized and holds off the need for nursing home care.

The Difficulties in Transitioning from Welfare to Work

A person's ability to make the transition from welfare to work is impacted by several significant barriers, according to research by the Urban Institute, including:¹

- ☐ Physical disabilities and/or health limitations
- ☐ Mental health problems
- ☐ Health or behavioral problems of children
- ☐ Substance abuse
- ☐ Domestic violence
- ☐ Involvement with the child welfare system

- ☐ Housing instability

- ☐ Poor basic skills and learning disabilities.

Most of these barriers can be addressed by a Neighborhood Networks center that provides health care programs and services designed to meet the needs of residents of HUD housing.

Low-Income People Have Greater Health Care Needs

Research has shown that people with lower incomes are less healthy than people with higher incomes and report more limitations in activities due to chronic health conditions. Furthermore, death rates from some diseases are two and three times higher in low-income people. One theory is that low-income people lack sufficient access to services.

Older People Need More Health Care Services

Increasing numbers of Americans are living into their 70s, 80s and beyond. Because people are living longer, their health needs are greater than ever.

The ability to live longer and independently depends in large part on how well a person can manage his or her own health. Services, such as classes in nutrition, medication and self-management of chronic medical conditions, promote independence, as do health assessments and screenings that provide frequent physical checkups.

Better Access to Services Can Mean Better Health

Low-income people, including seniors, have an enormous need for health care services. An important role for Neighborhood Networks centers is to improve the access to those services for their constituents.

Health care programming can support seniors in monitoring and self-managing chronic conditions, offer counseling to teenage mothers on parenting and child care, and counsel residents on substance abuse

and HIV/AIDS awareness. The specific needs vary, but the delivery of health care services is an integral part of the Neighborhood Networks goal of promoting self-sufficiency.

Chapter 2

Selection of Models

The models highlighted in this guide are actual examples of successful programs. They were selected because of their innovation in providing access to health care for low-income people. While only some models reflect practices at actual Neighborhood Networks centers, all are readily applicable to Neighborhood Networks centers.

☐ **Orchard Mews Neighborhood Networks Center**

in Baltimore, MD, in cooperation with the nonprofit Multi-Family Initiatives, provides residents with on-site substance abuse counseling and nurse case management to facilitate access to health care services.

☐ **Golden West Senior Residence**

in Boulder, CO, created a comprehensive Wellness Program by facilitating community partnerships that offer residents a variety of on-site services.

☐ **The Nurse Managed Wellness Clinic**

operated by the Duquesne University School of Nursing in Pittsburgh, PA, provides health promotion and wellness information to help seniors in remaining independent.

☐ **The West End Public Housing Primary Care Program**

in Atlanta, GA, has adapted the community health center model and used it at six public housing sites.

Criteria

These models were selected because they:

- ☐ Used housing as a delivery vehicle or were programs easily adapted to a housing setting
- ☐ Required varying levels of resources
- ☐ Met a specific health need in the community established through research, surveys or experience
- ☐ Designed programs with specific information on the health care needs of the residents/constituents and often included residents in the design.

☐ **Advocacy and Benefit Counseling for Health**

in Madison, WI, is an initiative organized by a public interest law firm. It links individuals with insurance coverage, explains benefits packages and advocates for consumers in insurance claim disputes.

☐ **The University of Michigan Kiosk Program**

in Ann Arbor, MI, uses telehealth to disseminate health care information. The use of interactive computers located in malls, libraries, recreation centers, work sites, hospitals and other locations easily accessible to consumers provides tailored public health information.

These models work with the help of a variety of partnerships providing on-site health care information and services. Varying levels of resources are required in each model. The examples range from a multi-property program that provides on-site clinic services performed by an interdisciplinary team to a single-site program that emphasizes nurse case management to facilitate access to medical services. All the programs meet a health care need in low-income communities. The models can be implemented in properties for families as well as the elderly.

The models relied on health care statistics of the organizations that performed needs assessments to establish needed services. Education about heart disease, the leading cause of death for all Americans over 65 and the leading cause of death among African Americans, is targeted in all models providing health care information and services. Diabetes, HIV/AIDS, substance abuse and infant mortality are also addressed in programs.

All of the models seek to empower residents through one or more methods:

- ☐ Involvement in the delivery of service
- ☐ Participation in supervisory committees and
- ☐ Assessment of resident needs and interests.

The following table describes each model.

Name of Program	Description
Multifamily Initiatives: Orchard Mews Neighborhood Networks Center, Baltimore, Md	Non-profit partner providing on-site services in a family Section 8 property. Staff includes an addictions counselor and a nurse. Supported by HUD Drug Elimination Grant
Golden West Senior Residence Wellness Program, Boulder, CO.	Neighborhood Networks center site with a service coordinator on staff who develops community partnerships to build a comprehensive Wellness Program.
Duquesne University School of Nursing, Nurse Managed Wellness Clinics, Pittsburgh, PA.	University-based training model running on-site clinics in two senior properties, one of which has a Neighborhood Networks center.
West End Medical Center, Public Housing Primary Care Program, Atlanta, GA.	A community health center program providing preventive and primary care services in six public housing sites. Supported by a U.S. Department of Health and Human Services, Bureau of Primary Health Care Services Grant.
ABC for Health, Advocacy and Health Benefits Counseling Program, Madison, WI.	Nonprofit public interest law firm dedicated to ensuring access to health care for families at risk by providing health benefits counseling to secure insurance coverage, explain benefits and advocate patients' reimbursements.
University of Michigan, Michigan Interactive Health Kiosk Demonstration Project, Ann Arbor, MI.	A University of Michigan telehealth project funded through Michigan tobacco tax dollars. Ninety interactive computers provide custom tailored public health messages at recreation centers, malls, hospitals, libraries and other locations in Michigan.

Chapter 3

Case Studies

Multi-Family Initiatives Orchard Mews Neighborhood Networks Center Baltimore, MD

Project Address:	514 Orchard Street Baltimore, MD 21201
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Introduction

Orchard Mews is a 101-unit development in the Seton Hill neighborhood of Baltimore. It receives Section 8 property-based rental assistance and is owned and managed by NHP/AIMCO. Property manager Angela Wickham was the inspiration behind the full-service Neighborhood Networks center established in August 1997.

Ms. Wickham believed that access to health care was an important component of welfare-to-work efforts. After visiting a program in Washington, DC, developed by Multi-Family Initiatives (MFI), she applied for a Drug Elimination Grant to start an MFI program at Orchard Mews offering residents on-site chemical addiction counseling and other services related to chemical dependency. The center uses a holistic approach to treatment, therefore addressing underlying physical and psychological issues. A secondary objective was to manage the health needs of the entire community by making home visits, performing medical assessments and making appropriate health care referrals.

The program is administered by Susan Tuft of Multi-Family Initiatives whose experience in Washington, DC, taught her that health care and treatment for chemical addiction among residents of low-income

housing must be addressed first so that they can maintain employment.

The MFI health care program at Orchard Mews was recognized as a 1998 John J. Gunther Blue Ribbon Best Practice by the U.S. Department of Housing and Urban Development. The award recognizes the very best community development programs in the country.

Program Description

MFI started its program in April 1998. It is located in a two-story townhouse across the street from Orchard Mews, thereby bringing on-site drug prevention and treatment services one step closer to residents. Two staffers serve the health care needs of the 342 residents of the Orchard Mews family property. A full-time registered nurse holds office hours in the townhouse and conducts home visits. A certified chemical addiction counselor works two days a week providing on-site counseling and door-to-door community outreach to residents.

Conducting home visits, attending community events and interacting with residents outside of the health center is essential to establishing a relationship of trust. Typically, a resident will see the nurse who conducts a comprehensive health assessment — essentially a head-to-toe examination, including the neurological, cardiovascular, pulmonary, musculo-

skeletal and psychosocial systems, as well as a nutritional assessment. Additionally, an assessment of the home environment can provide a better understanding of health needs. A course of treatment is determined and the connections to needed services begins. This includes linking residents with physician care and coaching them on how to secure the services they need.

For chemically dependent individuals, the counselor and the patient determine appropriate care, which can include referral to outpatient or inpatient care.

In addition to providing one-on-one health services to residents, the nurse monitors seniors with hypertension. Future activities include yoga instruction and other site-based health resources made available by partnering. All programs and services are free.

Program Funding

In 1997, a one-year Drug Elimination Grant of \$102,000 was awarded by HUD to replicate the Multi-Family Initiatives model of treating substance abuse and related health issues. Monthly expenses of approximately \$8,500 included:

- ☐ Full-time nurse
- ☐ Part-time (two days) certified substance abuse counselor
- ☐ Rent
- ☐ Utilities
- ☐ Supplies
- ☐ Project management

Implementation

Upon receipt of the Drug Elimination Grant, Orchard Mews was faced with adapting a successful program concept to a new setting.

Finding space was the first obstacle. MFI planned to offer services adjacent to the management office, but when the management office was relocated, there was no available space at the new site. MFI rented a

townhouse owned by the neighborhood church and located across the street from the development.

Identifying partnerships and how much control over the program they would exercise were obstacles. MFI had begun developing a partnership with a local nursing school, but the partnership ended because the nursing school did not want to practice in a church-owned site. MFI then established a partnership with Chase Brexton Community Health Center, a local community health clinic. The plan was to contract with Chase Brexton to hire a nurse to work at Orchard Mews. However, this arrangement left too much program control with Chase Brexton and too little with MFI. MFI chose to hire the nurse directly and Chase Brexton, because of its expertise in the field, would hire a part-time site-based certified substance abuse counselor.

Finding a nurse willing to work in the community was another obstacle. MFI subsequently hired a community health nurse who knew the public health resources in Baltimore City, was comfortable in the neighborhood and willing to make house calls.

Results

In the first five months of operation, there were an estimated 100 resident requests for services. The nurse had made many more calls on behalf of residents to link them to community health services and conducted more than 61 comprehensive health assessments and 76 home visits. A group of seniors was regularly monitored and given support for hypertension and a 6-week yoga class was well attended. Additionally, 14 residents sought services for addiction and 12 remained in case management after following treatment recommendations.

Lessons Learned

Several lessons have been learned in operating the health care program at Orchard Mews:

- ☐ Health care is a vital supportive service to offer low-income residents. Other programs will likely fail when health concerns are not addressed.
- ☐ Most residents want to improve their health.

-
- ☐ Programs must have on-site staff to overcome the barriers to accessing local community health centers, a primary care physician and other available health services.
 - ☐ Nurses are the most important people to employ to administer the program. Residents consider a nurse a primary care provider and medically qualified to understand and address many of their health concerns.
 - ☐ The property management company cannot operate the program. To disclose health concerns, residents need to trust the staff and know that this information will not be used against them in any way.
 - ☐ There is very little grant money available for these kinds of programs.
 - ☐ Partners are very important. However, be very cautious in their selection and have a few strong ones instead of many small ones. Developing a partnership demands a substantial investment of time. Partners should offer some resources and share a similar mission with your center. You also want to retain enough control over the program to ensure the original goals of the program are achieved.

Golden West Senior Residence Wellness Program Golden West Neighborhood Networks Center Boulder, Colorado

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Executive Director:	John Torres

Introduction

The Golden West Senior Residence is a three-building complex at the foothills of the Rocky Mountains in Boulder, CO. It includes 255 senior housing apartments in two connected high-rise buildings, one of which houses a Neighborhood Networks center. The first structure was built 33 years ago. The high-rises are privately owned Section 202 properties. The third, a four-story building directly north of the HUD property, was added approximately nine years ago and provides 56 units of assisted living for seniors. The Golden West Senior Residence Wellness Program is a comprehensive program providing services to seniors living independently and those needing assistance with activities of daily living.

The complex was built under the sponsorship of the First Christian Church in Boulder. When the organization built the facility more than 30 years ago, part of the mission was to provide on-site services for seniors. Jeanine Henderson, president of the Golden West board of directors and a member of the First Christian Church, comments, "Golden West has over the years successfully fulfilled its mission in Boulder by providing affordable housing and services to people aged 62 years and over. This was the original intention of the church in building Golden West and it continues today."

The Golden West Wellness Program provides 12 services. The objective of The Wellness Program is to assist seniors in taking responsibility for their own health by providing a number of on-site resources. The Wellness Program utilizes community partnerships to offer this comprehensive array of

services. The staff of Golden West seek out community resources that can serve the many needs of seniors. For most services, Golden West has not been required to provide financial support or administer these services.

Program Description

Golden West has over the years developed relationships with government, hospitals, universities, private practitioners and corporations to build a meaningful health care program. These partnerships include Boulder Community Hospital, the University of Colorado at Boulder Speech and Language Hearing Center, the Boulder County Health Department, Dental Aid, the Boulder County Mental Health Department, a private massage therapist, a private Tai Chi instructor and Professional Home Health. These partnerships provide convenient, high-quality and affordable services to seniors. Programs are developed and managed by a director of resident services and a service coordinator.

The complex is well-maintained and has adequate space for a variety of services. Most of the 320 seniors who live at Golden West are motivated to keep themselves healthy. Some residents cannot travel long distances for services. All residents have Medicare and some have supplemental health coverage. Residents do have some ability to pay for services and there is adequate space for service delivery.

The health care activities are intended to promote not only the physical well-being of residents but also their emotional, spiritual and intellectual well-being. The

services available at Golden West focus on wellness. This is accomplished by educating seniors about the symptoms of and predisposition toward certain conditions. By treating chronic conditions and receiving checkups while still healthy, residents are promoting their own good health. They are also addressing the psychological issues that go along with aging and managing chronic ailments. The services available through the Wellness Program cater to all the needs of seniors and enable them to stay independent. For example, when a resident returns from a hospital stay, the program provides two meals a day, rather than the one meal a day that all residents receive. To ensure that the necessary off-site services are accessed, the Wellness Program links residents to the public transportation system that subsidizes rides for seniors.

Features of the Golden West Wellness Program

Here are some of the features of the Golden West Wellness Program:

55+ Wellness Program – This is the longest operating service of the Golden West Wellness Program. It has been in existence since the 1970s. Registered nurses from the nonprofit Boulder Community Hospital are on site twice a month for six hours. The nurses perform a variety of procedures and attend to any health concerns that residents may have. They take vital signs and monitor chronic conditions. The program seeks to augment the services residents receive from their primary care physicians and specialists. It provides residents with a convenient way of getting health questions answered and gaining assistance in maintaining good health. Residents pay an annual fee of \$20 to participate. The hospital subsidizes the service. For the nonprofit hospital, it is fulfilling its community service mission.

Fit Feet – Professional Home Health provides a weekly, eight-hour foot clinic that addresses foot pain and discomfort. When necessary, the nurse attends to clients in their homes. This service is available to residents who are determined not to be homebound by a medical diagnosis that dictates ongoing foot care paid for by Medicare. Each clinic visit is \$18 and a home visit is \$24.

Boulder County Health Department Flu Clinic – Each fall, the health department conducts a clinic where nurses provide flu shots at no charge to residents with Medicare (non-HMO).

Kaiser Permanente Flu Clinic – Kaiser Permanente nurses conduct an on-site flu shot clinic. At the beginning of flu season, residents who selected a Medicare HMO were not eligible to receive free flu shots from the county health department because the service is available through their primary care physician. Knowing that 100 residents were enrolled in the Kaiser HMO, the director of resident services approached Kaiser about providing a free on-site flu shot clinic for its enrollees. Kaiser Permanente was very interested in seeing that their senior subscribers received flu shots.

Dental Screenings by Dental Aid – Dental Aid provides services to all low-income persons in the county. For the Golden West Wellness Program, Dental Aid obtained grants from the City of Boulder and A.V. Hunter Trust. The grants cover the cost of quarterly cleanings and x-rays on location. These services are free; other minor services are available on a sliding scale fee.

Boulder County Mental Health Clinic – For several years, a geriatric therapist has been on-site once each week. In 1998, volunteer peer counselors – seniors trained and supervised by the Boulder County Mental Health Department – began providing mental health services. The peer counselors know first hand the isolation many seniors experience and the emotions surrounding failing health. The peers play a short-term assessment and support role and are trained to identify when to refer a resident for additional services. They talk with the resident, assess the situation and offer their support to assist them in finding ongoing treatment if it is needed. The peer counselors and an intern working toward her professional counseling license are also trained to provide group services. Seniors in need of psychological support can gather as a group and work on specific issues.

Hearing Clinic conducted by graduate students of the University of Colorado Speech and Language Hearing Center – The relationship with the University

of Colorado Audiology Department began around 1990 when Dr. Sweetman, an audiologist, performed free on-site hearing tests. In the mid-1990s, the student-run clinic developed out of a need for providing residents with additional services once hearing loss was diagnosed. Residents are taught lip reading in a group setting each week. The students regularly assess the need for hearing aids and consult with residents about other such devices. Additionally, students conduct home visits with every participant in an effort to keep residents communicating optimally in light of hearing loss. Telephone amplifiers and lighted doorbells are two examples of hearing loss aids. The students also teach residents assertiveness skills so that they can obtain the necessary aids.

Professional Home Health Consulting Nurse – For assisted living residents, this service provides a medical consultation by a registered nurse from the home health agency at a reduced rate. Golden West pays the nurse \$15 an hour. The nurse is on site for an hour each day, Monday through Friday. This is not an emergency service, but the nurse can assist with many of the medical situations that arise each day. Unlike other assisted living facilities, Golden West does not employ health professionals. If a situation arises that requires immediate medical attention, Golden West staff must call 911. The on-site nurse assists staff with medical assessment or advice before a situation becomes a medical emergency.

Massage Therapy – Once a week for three hours, a private therapist provides 15-minute chair massages. The fee is \$10 and is paid for by the residents.

Tai Chi – A private instructor provides small group instruction for eight to 10 weeks to work on balance. The residents pay \$3 per session or approximately \$30 for the course.

Program Funding and Sustainability

Among their other responsibilities, the director of resident services and the service coordinator support the Wellness Program. Their role is to determine — with resident assistance — which services are needed, to pursue providers who offer the services and to assist providers in the development of on-site

programs. These positions are allowable expenses of the project.

Golden West offers its partners space for providing services. Providers subsidize some of the services for a variety of reasons. Universities use it as a teaching site, nonprofit organizations may be fulfilling a mission to provide services in the community and yet others may see their work as a way to market the high-quality professional services of their organization.

Periodically, providers ask Golden West to pay for services. Golden West's approach is to survey residents to determine interest. Residents are asked whether they are willing to pay (or pay more, in some cases) for a service. If they are not, the partnership ends. The exception is an on-site nurse who manages non-emergency medical problems among assisting living residents one hour each day. Periodically, Golden West makes these decisions as it considers the need to hire more staff or subsidize a service.

The sustainability of the Wellness Program's success depends upon maintaining the property in good condition, retaining space for services and continuing to match resident needs and potential partners' interests.

Implementation

The information on which services to include in the Wellness Program is gathered from many sources. The director of resident services and the service coordinator participate in monthly networking meetings of the Colorado Gerontological Society with the help of Boulder Manor, a local nursing home. The meetings are held at Golden West and provide educational information as well as an opportunity to network. This forum promotes community building and provides an opportunity to the members to determine whether seniors' needs are being well served community-wide. Golden West has historically maintained a high profile in the community and agencies approach them about bringing services onsite.

There are a number of ways that staff gathers information from residents about which services to

provide. Annually, one-hour floor meetings are held, led by the executive director. It is an opportunity for residents to discuss their concerns and for staff to propose ideas to residents. A pre-admission interview of each resident gives the staff a chance to establish a baseline of health service needs and available resources. Throughout the year, there are monthly resident council meetings. An annual survey measures resident satisfaction.

With so many partnerships, the logistics of where and when to offer each service is a challenge. The three spaces Golden West provides to the Wellness Program give providers three different types of rooms from which to choose.

With the opening of a new program, more staff support is required. There is an initial period where staff need to foster resident participation even if residents endorsed the program concept. As residents become more familiar with the service, the provider and where and when the service is offered, less staff involvement is required. Staff has made one exception to this successful strategy. Due to the need for privacy in providing mental health services, staff has never encouraged or facilitated resident participation. It is important for residents to know that their privacy is maintained.

Results

In 1998, Golden West established its first partnership with a managed care plan Kaiser Permanente, which provided flu shots on-site.

There have been no Wellness Program failures. All of the programs have been well-attended. This can be attributed to the advanced research to establish program appropriateness and plan for staff support.

In the 55+ program, approximately one-quarter of the residents are members and on each day the nurse is present, an average of 28 residents receive services. A satisfaction survey reported a 98 percent satisfaction rate.

The 55+ program and the Professional Home Health consulting service make physician medical appointments more informative and beneficial because of the education and information provided by

on-site nurses. Additionally, off-site physician appointments may be unnecessary for monitoring chronic conditions and checking vital signs. Another advantage of the Professional Home Health program is that if a resident develops a need for in-home health services, the transition is a smooth one because the resident is already familiar with a nurse who can provide those services.

Golden West has provided an opportunity for three to five University of Colorado graduate students in audiology or speech pathology to receive hands-on clinical experience each semester. The success of this program has resulted in the use of a \$5,000 donation toward the purchase of assistive listening devices. This means that more residents can participate in this program which has served as many as 40 residents.

Golden West residents are the most frequent users of the Special Transit Services of Boulder County. The service helps them keep medical appointments, go shopping and go on recreational outings.

Lessons Learned

Wellness Program staff have learned many lessons in their program operations.

- ❑ A community-wide network of gerontology professionals promotes community planning for services, raises the profile of each of the participants and educates the professionals on new information in the field.
- ❑ When a service is built on partnerships, it is important to be adaptable to change. Internal changes in partner organizations, such as staff changes, or changes in profitability or mission, may mean a modification in on-site services. With each change, staff review the impact on residents. Some changes may be acceptable and some may not. There are enough partners and potential partners that any one service is not considered indispensable.
- ❑ The need for on-site services is growing. The cutbacks in Medicare and the movement toward managed care have meant that residents return from hospital and rehabilitation stays quicker and

sicker. Additionally, Golden West has been in existence for 33 years and many residents have aged in place. The average age in the complex is 82 years. As people grow older, they typically need more health care services.

- ❑ Happy residents are often healthier residents. A service-rich environment not only addresses health concerns, but it provides an active community environment, gives residents interested and knowledgeable people to communicate with and shows them that staff care. On a satisfaction survey, one resident wrote, "I never dreamed I could feel as happy in retirement."
- ❑ The benefits of on-site services extend beyond what is readily apparent. Residents need to develop trust in a program before they will

access it. Having a service on site that is used by other residents and encouraged by staff invites participation. Once a resident uses a service, that service becomes more important to the resident. For example, some residents access off-site dental services because they received cleanings on-site. Good dental hygiene also encourages good nutrition. The mental health program is a service that many residents probably would never have accessed if it was not available in the comfortable, supportive environment of Golden West. Mental health counseling is used for an ever-expanding list of issues.

These lessons learned can help other Neighborhood Networks centers in their efforts to offer health care services to residents.

Duquesne University School of Nursing Nurse Managed Wellness Clinics St. Justin Plaza Neighborhood Network Center Pittsburgh, PA

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Introduction

Lenore Resick, assistant professor of nursing at Duquesne University, directs two nurse-managed wellness clinics in Pittsburgh, PA. Both clinics are in senior properties with Section 8 rental assistance.

In 1994, the first clinic was opened at St. Justin Plaza, a 97-unit building in the Mt. Washington area. It is owned by the Christian organization of the same name and managed by Sister Susanne Watson. St. Justin Plaza opened its Neighborhood Networks center in December 1997. The second clinic opened in 1995 at K. Leroy Irvis Towers, a 190-unit building in the Hill district of Pittsburgh. It is owned by a consortium of investors and is managed by Arbors, under the direction of Edward Quinlin.

The objectives of the clinics are:

- ☐ To promote independent living for seniors by providing health promotion and wellness programs on site for the residents of two high-rise properties.

- ☐ To facilitate access to primary care services so the elderly can live longer and healthier lives and provide preventive care as a means to avoid costly medical services.
- ☐ To provide a community-based and community-focused, cross-cultural health care experience for nursing, pharmacy and health science students.

In the early 1990s, two national health prevention agendas motivated Duquesne University's opening of the first Nurse Managed Wellness Clinic.

By the year 2000, 13 percent of the population will be over the age of 65². Because chronic health problems increase with age, the need for supportive services is increasing. The 1990 U.S. Department of Health and Human Services Healthy People 2000 campaign expressed goals to increase the years of healthy life to age 65 and beyond. One of the strategies proposed was providing health promotion programs to seniors. Early in the decade, the American Nurses Association proposed a health care reform agenda that emphasized wellness programming, equitable access to care and a consumer-focused health care system that encourages more responsibility for self-care in managing health. Nurse-managed wellness

clinics staffed by advanced practice nurses, such as nurse practitioners and clinical nurse specialists, are vital to this plan. Carol Taylor, a nurse from Duquesne University, opened the first clinic at St. Justin Plaza in 1994 to accomplish these goals.

In 1993, the University Provost Michael Weber began a community-wide planning process. He involved community partners and many schools within the University. He knew that the university had significant resources to offer and believed that the community could teach the faculty and students important lessons. The University was awarded a \$580,000 Community Outreach Partnership Grant from the U.S. Department of Housing and Urban Development. A second clinic site at K. Leroy Irvis Towers, modeled after the success at St. Justin Plaza, opened in 1995, utilizing some of the HUD funds.

Program Description

The wellness clinics are open an average of two days per week on Tuesdays and Thursdays from 9 a.m.-3 p.m. An advanced practice nurse who is also a faculty member is assigned to each site.

An advanced practice nurse is a nurse who is a licensed, registered nurse prepared at the graduate level as a clinical specialist, nurse practitioner, nurse anesthetist or nurse midwife. At the clinics, the advanced practice nurses are nurse practitioners. They develop clinic operations, manage clinic activities, provide direct care and plan and supervise student activities. The advanced practice nurse provides the program continuity that might otherwise be lost as the students change from semester to semester. On any day, one, two or three students from the schools of nursing, occupational therapy and pharmacy staff the clinics. The goal of all the activities derived from the three disciplines is to keep the seniors well through exercise, monitoring chronic conditions and providing health information on issues that impact their lives. Managing medication and preventing unnecessary hospitalization and premature institutionalization are important issues, as the average age in both facilities is 75 years.

The clinics have examination spaces but look more like apartments. Each clinic has chairs, tables,

curtains, carpeting and other features that make the physical space inviting. Clinic activities vary depending on the needs of the residents. Activities may include discussions about a future surgery and post-hospitalization plans. The advanced practice nurse or students under APN direction may review a visit made to a physician's office or discuss chronic conditions. Blood pressure is checked and weight measured. Occupational therapists frequently perform functional assessments and nursing students lead exercise classes.

The wellness clinics are designed to teach students how to render "culturally-competent" care, defined as care that is sensitive to a resident's culture, race, gender and sexual orientation. The students regularly facilitate workshops.

The relationship between the students and the seniors is mutually beneficial.

The seniors educate the students about the self-management of chronic conditions. The seniors also have a wealth of experience with the medical system so they provide the students with a better understanding of why some medically-recommended practices may have failed.

The service to seniors is unique not only because of its focus on wellness and not illness, but because it is frequently delivered by an interdisciplinary team. Information is often provided from multiple perspectives. For example, a student nurse may give a diabetic nutrition information and an assessment of weight and other symptoms of the disease. An occupational therapy student may work with the patient on performing exercises to promote greater blood circulation and overall mobility. A pharmacy student may ensure that the resident is administering the correct insulin dosage and is not taking other contraindicated medications.

The advanced practice nurse may perform a physical assessment if a client has a specific complaint. The wellness clinic is not designed to provide medical treatment but to augment medical care by offering health promotion and wellness services and by encouraging appropriate use of the health care system. If medical treatment is indicated, the patient

is encouraged to call his or her physician. Often, a client calls the physician from the clinic and both the client and nurse speak with the physician. The nurse can provide to the physician records on blood pressure readings and other assessment information gathered during clinic visits.

Graduate nursing students perform an annual chart audit and client satisfaction survey. The audit and survey usually result in program modifications the following year. All students are asked to complete a satisfaction survey of their clinic experiences.

Program Funding

The clinic at K. Leroy Irvis Towers opened with \$58,301 that Duquesne University received in the form of grant from the HUD Community Outreach Partnership. It covered the salary of the managing nurse and administrative support, as well as some supplies and equipment. The second year of the K. Leroy Irvis Tower's Nurse Managed Wellness Clinic was supported by a \$25,000 continuation grant from HUD.

Duquesne University has always provided financial support to St. Justin Plaza. Since January 1998, the university has been the primary funder for K. Leroy Irvis Towers. Duquesne University supports the wellness clinics in order to train students in a cross-cultural community setting while providing advanced practical nurse faculty a clinical practice site. The university pays for the salaries of the two advanced practice and nurse practitioner faculty members who manage the clinics. In addition to managing clinic services, providing direct care and planning and supervising student experiences, these faculty have other university responsibilities. The student involvement in the clinics is free. For students, this experience partially fulfills a requirement to practice in a community setting.

HUD no longer funds the program. Grants of \$1,000 each year for the next five years have been awarded by the Alumni Association of Presbyterian-University Hospital School of Nursing. The award funds supplies and the cost of a part-time administrative assistant. The supply expense and administrative support for St. Justin Plaza were approximately \$12,600 in 1996 and

1997, which is paid for by Duquesne University. The property owners provided the physical space for the clinic and some of the furnishings.

Implementation

The first clinic opened after Duquesne University nurse Carol Taylor considered the following factors: the experience of other nurse-run clinics, results of a survey that revealed that residents had health insurance and primary care providers, and the limited funding available. A duplication of primary care services was not necessary. The experience of other nurse-managed clinics and a survey done of the community's existing medical services suggested that health promotion activities for seniors were scarce services. The nurse managed wellness clinics are designed to augment the health services already available to seniors.

One of the challenges to a successful health promotion and wellness clinic is distinguishing it from a medical service. Typically, people access health professionals when they are ill. A successful health promotion and wellness clinic serves clients before this stage. Determining additional services residents value requires gathering information about the health issues being managed day to day. This is a needs assessment, of which there are two aspects; resident-perceived needs and needs defined by trained health professionals. The latter can be determined by a health assessment or chart audit.

Another factor in the success of a wellness clinic is that each resident may have a different definition of wellness. Ms. Resick and staff see their roles as facilitators. "We assist residents in defining and achieving wellness", Ms. Resick explained.

Succeeding in this effort requires expert listening skills. In order to obtain credibility with residents of K. Leroy Irvis Towers, the help of the on-site social worker who had successfully served the residents for years was enlisted. The social worker became Ms. Resick's liaison until she built her own relationship with residents. "Unlike the process at St. Justin Plaza, the needs assessment at K. Leroy Irvis Towers transpired through informal communication with residents," she said. At St. Justin Plaza, the residents

tend to be very active in resident council meetings. About 90 percent participated in a council meeting that served as a focus group to determine clinic activities. Residents were urged to visit the clinic for an initial health assessment to establish a baseline of data on their health. In both cases, residents responded.

The experience at K. Leroy Irvis Towers was very different. Residents were suspicious of the need for a formal baseline health assessment since they were already under physician care. Clinic staff had to develop a trusting social relationship with clients before clients would begin to divulge information regarding their health concerns. This relationship developed by taking time to get to know the residents and giving them time to get to know the nurse. This happened by having one nurse regularly at the site, keeping consistent hours, attending many community events and explaining the need for baseline information.

Residents feared being studied for research purposes. Although they willingly participated in clinic activities, many residents still considered the formal health assessment too time-consuming and unnecessary. As a result, a baseline of health information for the population was established — not by doing a formal health assessment, but by performing a chart audit of the medical records maintained by the clinic.

Although the process for obtaining information regarding the needs of the residents varied greatly between the site at K. Leroy Irvis Towers and St. Justin Plaza, the primary health issues are the same. Three main areas of concern for seniors at both sites include hypertension and the need for blood pressure monitoring, nutrition and maintaining optimal weight, and managing multiple medications.

Results

By 1998, there were nearly 4,000 visits to the Nurse Managed Wellness Clinic at St. Justin Plaza and more than 1,732 visits to the clinic at K. Leroy Irvis Towers. More than 70 percent of seniors at the two sites participate in program activities.

Residents are able to live independently longer and the centers have improved the quality of life at St. Justin Plaza and at K. Leroy Irvis Towers. The social interaction surrounding clinic activities reduces the isolation residents often experience when moving away from family and friends and into a senior facility. Furthermore, teaching students about chronic illnesses and their experiences with the medical system bolsters their self-esteem.

Each year, more than 100 students gain experience at the two clinics, often changing their opinions of the capabilities of seniors as a result, students say. Surveys of students' satisfaction generally rate the experience high and include that it has taught them about culture, healthy aging and health care in the context of community.

For these and other contributions the nurse managed wellness clinics received international recognition by being awarded a 1996 International Archon Award by Sigma Theta Tau International Nursing Honor Society. In 1997, the clinics were awarded a Certificate of Honor by the Hospital Council of Western Pennsylvania in recognition of "their excellence and impact in improving community health." Additionally, the Butler Pennsylvania Visiting Nurse Association replicated the clinic model and four local agencies expressed interest in doing the same.

Sustainability

The nurse managed wellness clinics are teaching sites and funded in large part by Duquesne University. To ensure that the university continues to fund the projects, strategies have been implemented to keep administration informed of how the clinic supports the university's mission.

Alternative funding sources for the entire program are unknown. However, small sums for supplies have been obtained. Also, exploring relationships with alumni organizations, local foundations, hospitals, visiting nurse associations, churches and health departments was considered.

Lessons Learned

Know the Requirements of a Community Health Nurse

The role of the nurse manager in a community wellness clinic requires:

- ☐ Advanced clinical expertise as well as knowledge of Occupational Safety and Health Administration and local health department regulations, which dictate what can and cannot be performed at the site;
- ☐ Communication skills;
- ☐ Sensitivity to individual needs;
- ☐ Good clinical skills;
- ☐ An intuitive sense for identifying influential community leaders; and
- ☐ The ability to be open and honest.

Many nurses who work in community wellness settings need to make adjustments from acute care settings. For example, the pace of activity is different and the environment is more like a home than a hospital.

Gather Information on Health Needs of Residents

Information regarding what services are needed should be obtained by identifying the residents' perceived needs and objectively establishing the health status of the residents. "The processes for gathering both sets of information can vary greatly from location to location," Ms. Resick said, because each community has a unique culture. "In order to be successful in this endeavor, the services must be community-focused and not just community-based," she said. This means understanding individuals' beliefs about health and providing services that are valued and delivered in a manner acceptable by the community.

Evaluate Provided Services and Measure Health Improvement

Measuring outcomes of senior wellness programs is challenging. The classification systems that exist for documenting health issues are built around the identification of a health problem. Clients do not always come to the wellness clinic because of a medical problem. Charting in a community-based setting where wellness activities occur requires much broader categories for classifying why residents are participating and what plans are in place for achieving wellness. Without uniformly collecting data on the clients, improvements in health across the population are impossible to measure.

West End Medical Center, Inc. Public Housing Primary Care Program Atlanta, GA

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Introduction

According to Karen Williams, program director at the West End Public Housing Primary Care Program, it was well recognized at the Atlanta (GA) Public Housing Authority that access to health care is an important link to resident self-sufficiency. Daisy Harris, the long-time executive director of West End Medical Center (West End), saw that West End provided a very valuable service in low-income communities, but also knew that there were many community residents who were not accessing services. Atlanta health statistics on infant mortality, teenage pregnancy and child immunization showed that the community health centers still had much work to do. Mrs. Harris considered whether there was another model of health care that would serve the disenfranchised population. Together with the Atlanta Public Housing Authority, Mrs. Harris, staff and board of West End Medical Center began to adapt the community health center model to locations within public housing.

In 1991, West End started the first two on-site clinics in public housing developments in Atlanta, GA. The objective of the now six on-site clinics is to increase health services access to people in great need by providing a convenient and targeted health program. Teen pregnancy, infant mortality, hypertension, on-time immunizations and substance abuse are public health issues that have been targeted.

Program Description

The clinics are in various public housing communities throughout Atlanta. The smallest property is a 250-unit high-rise senior development. The other five are low-rise family properties, the largest of which has 740 units. At the senior property, West End converted a one-bedroom apartment into clinic space; at the largest development, it converted three two-bedroom units. Similar services are provided at all six sites. However, the frequency of services, hours they are offered and the providers vary depending on the physical space and residents' needs. All clinics are open Monday through Friday, 8 a.m.-5 p.m., except for the smallest clinic which is open once a week. Clinics based at family properties provide a Women, Infant and Children (WIC) nutrition program which includes nutrition counseling and food vouchers that residents can use at authorized food stores. These sites provide obstetrics and gynecology, pediatric services, adult medicine and some laboratory testing.

Social workers provide case management services designed to connect residents to other social and medical services in the community. An important component of the on-site services is health education activities, including information on family planning, violence prevention and substance abuse. A health educator rotates through all six sites, providing health education information and arranging for experts to deliver on-site information sessions. Some health education is offered on the weekends in order to take advantage of scheduled community events.

Each site has an office manager, two licensed practical nurses, a part-time nutritionist, a part-time nurse midwife and a full-time physician's assistant. In Georgia, under physician supervision, a physician's assistant can write prescriptions and bill insurance plans for services. Additionally, each site has a physician on-site part-time who provides full-time backup for all health professionals. The physicians are board certified in pediatrics, internal medicine, family practice or obstetrics and gynecology. One registered nurse supervises the licensed practical nurses by rotating throughout all of the sites.

An important aspect of the success of the on-site clinics is the outreach by resident workers who are employed at each location. They do not diagnose or treat patients; instead, they make in-home health assessments, including blood pressure monitoring. By making home visits, these outreach workers help break down the psychological barriers patients have to obtaining care by building a trusting relationship. In addition, they educate residents in the safety and security of their own home about their need for services. Outreach workers have a high school diploma or equivalent.

Program Funding

In 1990, the Public Health Service Act was amended to authorize the targeting of primary care services to residents of public housing. The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration's Bureau of Primary Health Care established the Public Housing Primary Care Program. In 1991, West End was awarded a \$500,000 grant to provide on-site services to public housing residents. The grant has been renewed annually and increased to \$675,000 in 1997. The grant can be used for West End's so-called "soft" costs, including staff, medication, equipment and supplies. It cannot be used to rent and/or prepare the clinic space. The Atlanta Public Housing Authority provides the space and makes modifications to it for use as a clinic.

The total budget for the West End Public Housing Primary Care Program in 1997 was approximately \$1.2 million. The difference between operating costs and the Health and Human Services grant comes

principally from three sources: Medicaid reimbursement, fees from residents who do not qualify for Medicaid and small grants of \$20,000-\$50,000 from a variety of sources.

"It is a struggle every year to make ends meet," said Program Director Karen Williams. Many services not covered by Medicaid are considered important, including case management, nutrition and other education services. Even if a service does qualify for reimbursement, limits have been placed on the number of allowable visits for that service. Residents frequently run out of Medicaid-authorized visits before the need has been satisfied. Despite the challenges, Ms. Williams maintains a positive outlook. "The program is part of a larger medical community and has citywide supporters so even though it is a challenge each year to meet the budget, there are many committed individuals supporting the effort," she said.

Implementation

Once West End received the first Public Housing Primary Care grant, a program director was hired and provided the citywide health information, including the need for services. However, the public housing units to target and services to provide remained in question.

Of the 42 public housing buildings in Atlanta, the program was targeted to sites where resident councils were very strong. Without strong resident interest and involvement, they did not expect to succeed where off-site community health centers had failed. In addition to planning the program with the resident councils, West End went door to door to conduct health surveys. Not only did this result in increased awareness of the program, but it provided a complete health profile of the residents. At this point, it was decided which services to offer.

An early challenge was the modification of public housing units into adequate clinic space. This is the responsibility of the public housing authority. Clinic openings have been delayed because space was not ready for occupancy and clinic staff has had to devise ways to provide services without space. Services have been delivered from alternative spaces, such as

a van, the management office and often at community events. These efforts were at one time only reactions to unfinished clinic space but have become successful strategies for building public awareness prior to a new on-site clinic.

As part of a larger community health center, the Public Housing Primary Care Program has been able to share staff with other programs when a full-time person was not needed. Now with six sites, the program supports most of the staff full-time by rotating them between the sites. A few of the physicians split their time between the community health center and the Public Housing Primary Care Program.

Results

Of the 8,000 residents living in the six public housing sites, 86 percent have used the services of the clinics. Of the 14 percent who have not, some have relationships with other health care providers. Staff at the senior center clinic performed 1,500 services last year. Throughout the six sites, staff of the Public Housing Primary Care program performed 12,000 health services, including case management.

Sustainability

To a large degree, the program is dependent on the HHS grant. No other major source of funding for this program has been identified. One strategy to decrease the dependency on this grant has been the development of a for-profit umbrella corporation that delivers health care services to privately insured patients. Profits from this corporation are used to subsidize designated programs of West End Medical Center.

The Public Housing Primary Care Program is looking very closely at how efficiently each site is run and how to bill insurers for more of the services. Historically, only one set of financial records has been maintained for all the sites. The importance of knowing how efficiently each site is operated has become apparent. Therefore, separate financial records are being set up for each site.

Ms. Williams hopes that two recent developments will positively impact the program. The Children's Health Insurance Program (CHIP) has been enacted by Congress to allow states to cover more health services for children by providing federal matching grants. This program may cover more of the services already provided by the Public Housing Primary Care program. Also, the Atlanta Public Housing Authority has turned some of the developments served by the Public Housing Primary Care Program into mixed-income facilities. Both low-income and middle-income residents now occupy the converted sites. With middle-income residents accessing the on-site services, the Public Housing Primary Care program will be able to bill third-party payers.

Lessons Learned

Several important lessons have been learned in the establishment of the West End Medical Center's Public Housing Primary Care Program. These lessons are:

- ❑ Create a structure that will give the program resident input in program implementation as well as throughout the life of the program.

Although West End and the staff of the Public Housing Primary Care Program chose sites and selected services by assessing resident interest and needs, a structure to continually receive feedback was not in place. Now, each public housing site has an advisory committee of 10 clinic users who meet quarterly. Their task is to advise the management on the quality of the clinic operations. For example, if waiting time for services is too long or if staff behave unprofessionally, the committee will inform management. Additionally, a President's Council represented by the presidents of individual resident councils, monitors programming in all locations. Karen Williams, the program director, also sits on this committee.

- ❑ Resident outreach coordinators are essential to the success of the program, but how much information about other residents they acquire and which residents to hire for the job needs to be carefully considered.

An outreach coordinator's primary responsibility is to connect people to available services. Details of a patient's health or specific condition need not be known in order to refer a resident for services. Outreach coordinators need to be flexible in their approach to residents. How a coordinator successfully encourages compliance with medical regimens requires creativity.

- ❑ To encourage compliance with care routines, it is important to reduce the need to seek off-site services.

With seven years' experience, the West End Public Housing Primary Care Program remains committed to creating a continuous care system that treats all of a patient's health care needs. The program is working toward adding an on-site addiction's counselor.

- ❑ Community partnerships are essential to the success of the program.

Even though it may be desirable, it is fiscally impossible to bring on-site all services residents need. Linking to existing programs facilitates access to off-site services. Additionally, the partnership with the West End Medical Center, a longtime community health center, not only raises most of the program's funding, but also allows the PHPC program to take advantage of the partnerships between West End and local hospitals and health plans.

ABC for Health Inc. Health Benefits Counseling Program Madison, WI

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Introduction

ABC for Health Inc. is a nonprofit public interest law firm dedicated to ensuring health care access for children and families, particularly those with special needs or at risk. Since 1990, the Health Benefits Counseling program of ABC for Health has assisted families in qualifying for Medicaid and Medicare and assisted in dispute resolution with insurance companies regarding payment of claims. The program is a marriage of community-based advocacy and public interest law. It exists because public health insurance programs that many low-income people rely on are complicated. Who qualifies? Which managed care plan is optimal? What services are eligible for payment? These are a few of the questions ABC for Health helps families answer. There is little accessible and understandable information to help individuals answer these questions on their own. Medicaid and managed care plans have limited staff to help navigate the complex health care system.

ABC for Health employs health benefit counselors who teach consumers and train consumer advocates on how to qualify for medical assistance. They educate consumers about the nuances of the benefit plan and advocate on their behalf if reimbursement issues arise with a third-party payer. ABC for Health has developed a cadre of community advocates who are trained as health benefits counselors.

Founder Robert Peterson based the idea for the program on a similar program that provided health benefits counseling services to senior citizens. While working at the Seniors Benefit Program in the early 1970s, he was frequently asked to assist non-seniors with health insurance problems. He realized that no equivalent program existed for other segments of the population. With the advent of managed care and an industry-wide effort to cut costs, health insurance regulations have become increasingly complex. The need for health benefits counseling for all patients has become more pressing. Mr. Peterson decided to replicate the successful Senior Benefit Program but to add additional information that addressed the needs of all health care consumers regardless of age, thereby establishing the ABC for Health program.

Project Description

ABC for Health's work reduces the vulnerability of the poor and medically needy to economic hardship and neglected health needs. It does this by reducing the confusion and frustration in accessing the health care system, by easing the financial burden of seeking care and allows families to focus on their health needs. The program benefits residents throughout Wisconsin. Six instructors train an average of 200 persons a year in Health Benefits Counseling, using a variety of training formats. Individualized advocate training sessions take place over one to two weeks, followed by an apprenticeship. After that, as regulations and programs rules are modified,

meetings are scheduled for an update of information. There are also small, three- to five-day group trainings and ongoing workshops on a specific topic. The training topics include:

- ☐ Medicaid eligibility and benefits
- ☐ Social Security Income and Disability determination
- ☐ Health insurance denial negotiations
- ☐ Appeals procedures and strategies
- ☐ Programs for children with special needs
- ☐ Other financing resources
- ☐ Counseling and advocacy techniques

Counselors gain comprehensive knowledge of how health systems actually work and affect families. The audience of a training program not only includes health care consumers and consumer advocates, but social workers, patient account staff, managers of health care facilities and government representatives. The topics of the health benefits counseling curriculum are based on an examination of the daily health insurance issues of citizens. The curriculum is modified as new changes to insurance laws and regulations take effect.

The success of the program led to the opening of a 1,000-sq. ft. training site.

Program Funding

Program operations are supported by a Rural Health Outreach Grant from the Health Resources and Services Administration, state grants for health care training, Maternal and Child Health Block Grant funds, Older Americans Act funding and a grant from the Otto C. Bremer Foundation. In addition, in-kind volunteer services are valued at approximately \$40,000 annually. Furthermore, the subsidized legal fees ABC for Health charges consumers generate another \$60,000 annually. Law students from the University of Wisconsin Law School do legal work for ABC for Health and 60 percent of their salary is paid by the university through the federal government's work-study program. The program provides part-time

jobs for eligible students who demonstrate financial need. Students who hold jobs off-campus must work in positions that promote the public interest. Finally, fee income is generated from individuals who take the training courses.

Implementation

Convincing people throughout the state that there was a need for health benefits counseling was a tremendous challenge. Most consumers assumed that government and insurance companies were telling them everything they needed to know to protect their rights. However, many consumers experienced a number of obstacles to understanding medical bills and resolving disputed claims but their difficulties had not been well publicized. Mr. Peterson identified program stakeholders by contacting his colleagues in the Wisconsin Bar Association; establishing partnerships with grassroots community-based health organizations and local hospitals and by using the resources of state and local governments. The law firms that became program participants provided legal services pro bono or at a dramatically reduced cost to consumers. Mr. Peterson successfully recruited local law school clinical programs, convincing them to allow students to do legal research on behalf of consumers under the supervision of an attorney.

The health care institutions became stakeholders because they saw the financial benefits of having well-trained health benefits counselors identify alternative funding sources for persons with no health insurance coverage. Advocacy organizations were supportive because they realized they were gaining the knowledge and skills needed to negotiate medical claims with health insurers on behalf of consumers.

Results

In the decade since the staff of ABC for Health began providing health benefits counseling services in Wisconsin, more than 7,000 families, health care professionals and providers have benefited from information and counseling about health care financing programs, coverage options and insurance claim disputes.

One provider, the Dean Medical Center, seized on the concept of health benefits counseling and adapted the curriculum to its own private setting. Dean has a large clinic in Madison and several satellite clinics in surrounding southern Wisconsin counties. Partnering with ABC for Health for training counselors, Dean set up an Advocacy and Community Services program, which reviewed all requests for care assistance from the Dean Foundation. From September 1992 to September 1996, Dean recovered \$1,358,800 on behalf of more than 1,000 families. This is similar to the experience of benefits counselors in northwest Wisconsin. A review of cases in Polk and Barron counties from as early as 1990 documented the recovery of nearly \$1 million, mostly from private insurance. In these counties, the use of benefits counselors also helped increase enrollment of uninsured children in Medicaid.

The health benefits counselors and attorneys at ABC for Health have together advocated for families in coverage and claim disputes with insurance companies, health maintenance organizations and government programs. In doing so, they helped recover hundreds of thousands of dollars for health care consumers and providers in "lost" third-party reimbursements from public and private sources. In fact, their research indicates that each dollar spent on health benefits counseling generates more than \$10 in third-party payments.

In addition, counselors have been successful in reversing the decisions of health insurance companies that would have denied consumers access to durable medical goods, such as wheelchairs and walkers, and specialty services, such as occupational therapy and speech therapy for children.

Sustainability

Since 1987, ABC for Health has leveraged funding from the government, foundations, universities and the health care industry to develop consumer advocacy training programs in partnership with a highly respected, public interest, nonprofit law firm. These funding sources contribute toward program operating costs. In fall 1998, ABC for Health opened a new on-site training center. The number of firms and individuals requesting training services was at an all-time high. Each year, ABC for Health generates income from their training programs. Funding is stable and the biggest challenge is meeting the demand for counseling services.

Lessons Learned

Robert Peterson, the founder of ABC for Health, has provided health care benefits counseling services to the citizens of Wisconsin for more than a decade. His experience has taught him the following:

- ❑ Establish local partners and get support for your program from the key people in national, state and local government agencies and health care institutions. Their support for the training program is important for fundraising and obtaining program information. Many of these institutions enroll their employees in benefits counseling training with ABC for Health.
- ❑ Obtain enough funding so that the program can be offered on a continuous basis. If the service is not ongoing, class participation drops, funding sources become scarcer and the overall momentum of the program declines.
- ❑ Invest the resources in staff and training materials that convey professionalism. Community members will support you if they believe you provide high-quality products and services.

-
- ☐ Train key people in the operation of your entire organization. At a later date, if another firm hires those individuals, they will take with them a strong foundation of how to conduct health benefits counseling. The entire community will benefit from their knowledge.
 - ☐ Take advantage of all of the free information government agencies and corporations offer on the Internet. Immediate access to health program rules and regulations will significantly reduce the time you will spend on the phone requesting the information.

The University of Michigan Comprehensive Cancer Center Michigan Interactive Health Kiosk Demonstration Project

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Introduction

The Michigan Interactive Health Kiosk Demonstration Project is a network of computer-based interactive health programs located in kiosks throughout Michigan. The kiosks provide public health information targeting underserved populations. They are in places highly accessible to the public, including libraries, work sites, recreation centers, churches, grocery stores, malls, health departments and hospitals. This telehealth project aims to inform people in Michigan about disease prevention and good health.

The idea was the brainchild of Dr. Victor Strecher, a professor at the School of Public Health at the University of Michigan. He is also director of cancer prevention and control at the Comprehensive Cancer Center and director of the Health Media Research Laboratory at the University of Michigan.

Dr. Strecher's research indicated that public health campaign information tailored to the recipient is more likely to be understood and acted upon. Ideally, this type of tailored information will take into account an individual's background, needs, interests, motives and any barriers to making a health behavior change.

Printed materials, such as pamphlets, are mass-produced and, therefore, generically written. They are also widely and often indiscriminately disseminated. For these reasons, they are not effective as

communications devices. On the other hand, interactive computer technology that closely resembles television that is familiar to almost everyone is a more successful communication tool. Users can navigate through channels and receive health information on specific and it can be personally tailored to their individual health risks.

Dr. Strecher proposed the project to Michigan State Sen. Joseph Schwarz, vice-chairman of the senate appropriations sub-committee on community health. Tobacco tax dollars from the Michigan Department of Community Health funded the program for two years. The Health Media Research Laboratory was awarded \$2 million and received half in October 1996.

Project Description

"The kiosks are television-like and employ touch-activated screens that allow users to explore health information with a press of their finger," says Dr. Strecher. Audio imager domes that localize sound around the user are suspended above the kiosk. The rich stereo sound connects the user with on-screen visual imagery, creating a vivid, personal and private experience. Five health "channels," collectively identified as the "Health-O-Vision" program include Smoking Cessation and Prevention, Childhood Immunization, Breast Cancer, Prostate Cancer and Child Bicycle Helmet Safety. The channel topics are relevant to a broad range of people. Future channels include Cardiovascular Disease and Risk Prevention,

Cancer Risk Prevention, Physical Activity, Nutrition and Sexually Transmitted Diseases. The topics were selected based on the Michigan Department of Community Health's Critical Health Indicators which provide an overview of the health of state residents and the health system that serves them.

The Michigan Interactive Health Kiosk Demonstration Project's health messages speak to a person's beliefs about perceived risks of the target behavior, perceived benefits of changing the target behavior and the barriers to changing it. This approach can be seen in the main menu selections of the Smoking Cessation and Prevention Channel, which offer the following as entry points to users:

- ☐ "Is Smoking Really That Bad For Me?" (Perceived Risk)
- ☐ "Will Quitting Do Me Any Good?" (Perceived Benefit)
- ☐ "How Do I Quit?" (Barriers to Change)

The essence of the interactive experience is that the health messages can be tailored to the recipient. Tailored information happens in two ways: through interactive choices that allow users to create their own education experience; and through three programs that solicit information from the user and tailor the response. According to Dr. Strecher, people are more often motivated to change a behavior or take other action if the message specifically addresses their needs.

The 12-person project staff includes multimedia programmers, public health specialists, health educators, graphic designers and administrative staff. University of Michigan graduate students also support the project. Health educators on staff write the public health messages for the channels and a scientific advisory group University of Michigan physicians reviews the content. The final approval comes from the Michigan Department of Community Health. The kiosks are continually updated with new programming via a connection to a central computer server at the University of Michigan.

In 1998, there were 90 kiosks throughout the state. For the first year of the program, the process for

distributing the kiosks was by requesting proposals from interested organizations. A statewide media campaign resulted in applications for kiosks.

The criteria to select sites included answers to the following:

- ☐ How populated is the area?
- ☐ What is the socioeconomic status of the local population?
- ☐ What is the minority representation in the area?
- ☐ What does the physical location look like?

In the second year, in addition to receiving applications, staff sought out specific locations for new sites. The more proactive approach to finding new sites resulted in higher utilization of the kiosks.

In high-density locations where there are multiple kiosks, members of the Community Advisory Board with statewide representation oversee the promotion and utilization of the kiosks. The board is made up of representatives from local health departments, local health organizations and kiosk sites. Its role is to provide feedback to the staff on existing channel programming and new programming ideas, organize consumer focus groups and facilitate relationships with potential funding sources. This formal process was needed to gather ongoing feedback from users and non-users.

Program Funding

The sole source of funding for the project is the cancer section of the Michigan Department of Community Health. The proceeds from Michigan's tax on tobacco products fund health care projects. The Michigan Interactive Kiosk Demonstration Project was awarded a two-year grant of \$2 million in 1996 and grants from federal agencies have been pursued.

Implementing the Program

Once funding was received from the state, the development of five multimedia health channels became an intensive 12-month effort requiring more than 20,000 cumulative person-hours. The project was divided into five stages:

- ❑ **Analysis** – In this stage, it was determined which health and screening behaviors should be addressed. The challenges of effectively communicating each chosen message were defined by considering the specific health risks, barriers to good health behaviors and the benefits of changing behavior.
- ❑ **Design** – This phase involved planning the communication materials, testing the design concepts with users (both text and media) and settling up the major features of the software and hardware.
- ❑ **Development** – Flow charts for the contents of each health channel were created. Scripts were produced, creating many separate health messages, and storyboards were designed for each screen. The scientific accuracy of the health messages was verified and the scripts were edited. The software was programmed and tested for bugs and a critical review of the design took place.
- ❑ **Deployment** – The program was piloted in three communities with several kiosks in each location. Users were surveyed for their feedback and the software was debugged. Following this test, final versions of the kiosks were deployed to locations throughout the state.
- ❑ **Production** – Project promotion and partnerships for establishing a strong network were the focus. Maintaining and upgrading the software was also a priority.

Results

Usage of the kiosks was determined by analyzing two different types of data: on-screen user surveys and touch screen usage data. Both sources were collected by the kiosks and then uploaded daily by modem for analysis at the University of Michigan's Health Media Research Laboratory. Touch screen usage data was analyzed to determine the number of people who used the kiosk, which channel each user accessed, the amount of time the user spent looking at the channel and the path the user took through the information.

Statistics from the usage of the first 30 kiosks found:

- ❑ 16,987 users accessed information during an average 35-day period
- ❑ An average of 468 users per day
- ❑ An average of 15.6 users per day per kiosk
- ❑ An average of 3.4 minutes spent per user

Based on results from the first year of operation, the relative success of each channel can be seen. Of the channels selected, the most popular was the Bike Safety Channel, with 28 percent of users choosing it. The percentage of users who watched each channel is shown below.

Based on total users of the kiosks, the information shows the most popular channels or the frequency of its selection:

❑ Bike Safety Channel	28%
❑ Smoking Cessation Channel	27%
❑ Immunization Channel	23%
❑ Breast Cancer Channel	19%
❑ Prostate Cancer Channel	17%

(Fourteen percent of users chose more than one channel.)

Thirty-seven percent (6,300) users completed an on-screen satisfaction survey. The responses included:

- ❑ Of the on-screen survey respondents, one quarter reported having little or no computer experience.
- ❑ Nearly 59 percent of respondents identified themselves as minority, compared with the 16.5 percent of Michigan's population.
- ❑ Girls ranging in age from 10-19 years were the most frequent users among survey respondents.
- ❑ Males under age 50 were those most satisfied with the experience.
- ❑ More than 63 percent of the respondents said they would recommend Health-O-Vision to others.

- ☐ Malls, multi-merchandise stores and community colleges were seeing the greatest number of users.

Sustainability

At present, funding is secure. Future funding sources have been identified and some grant applications have been submitted. One grant from the Alzheimer's Association to produce an Alzheimer channel has been awarded. The following activities are essential for sustaining the success of the project:

- ☐ Development of future health channels. Categorical funding for individual health topics, such as the funding provided by the Alzheimer's Association, is an opportunity.
- ☐ Acquisition and deployment of additional kiosks.
- ☐ Maintenance, repair and upgrade of kiosks and software.
- ☐ Installment of telephone lines for optimal sites that cannot afford installation.
- ☐ Regular updating of local health resources for kiosk locations.
- ☐ Continued data collection and analysis of the success of specific channels and health messages, as well as kiosk locations, to maximize the dissemination of needed health information.

Lessons Learned

During the implementation and operation of the Michigan Interactive Health Kiosk Demonstration Project, staff learned many important lessons about how to improve delivery of the health messages:

- ☐ Improve signage around the sites to attract more attention.
- ☐ Instruct the user immediately on how to interact with computer.
- ☐ Publicize that health information is free.
- ☐ Make health channels available on CD-ROM and the Internet.

- ☐ Give the user the option to take away printed material from an interactive session.
- ☐ Give the user information on local health resources.

Additional lessons about the implementation of the project:

- ☐ Over extension of staff time and energy is a hazard.
- ☐ Public health delivered through interactive advanced technology requires the collaboration of many different disciplines. Large diverse group interaction needs a concrete supportive process.
- ☐ A formal process with a large funding agency, like the Michigan Department of Community Health, is required to ensure that communication is frequent and the contributions of the department are fully maximized.
- ☐ A statewide network of supporting organizations must be developed for multiple purposes, including promoting the project, receiving consumer feedback, monitoring kiosks and identifying funding sources.

The lessons learned are an important byproduct of the success of the Michigan Interactive Kiosk Demonstration Project. In 1995, Dr. Strecher chaired a conference entitled "Consumer Health Informatics: Issues and Challenges" attended by researchers and commercial developers of health-related advanced communication technologies. These experts agreed that by 2007, interactive television would reach many individuals who have never owned or used a computer. The Michigan Interactive Kiosk Demonstration Project has begun to develop the infrastructure for the age of interactive television. It is a bridge between public health and modern communication.

Chapter 4

Implementation: Adapting Use Ideas for Neighborhood Networks Centers

For the individual Neighborhood Networks center, implementing the practices described in these model programs may seem daunting because of their cost, size and complexity. Most Neighborhood Networks centers are not expected to replicate these models on the same scale as they are presented. The goal is to present a range of approaches to providing on-site health care that a Neighborhood Networks center can modify to meet the needs of its own community within existing constraints. At the same time, an ambitious center with the right partners can indeed create a robust program that rivals these models.

Most centers that decide to include or enhance health information and on-site services will begin with a more modest approach. For example, if resources are not available to have an on-site nurse on a full-time basis, a center could work with a partner and have an on-site nurse one day a week.

Golden West, Multi-Family Initiatives, Duquesne University and West End Medical Center illustrate health care programs located at low-income housing sites. They are presented so Neighborhood Networks centers can replicate these models in whole or in part with the collaboration of health care partners.

ABC for Health and the Michigan Interactive Kiosk illustrate programs and organizations that provide services that could be located at low-income housing sites. These models show the kinds of advocacy and telehealth activities that would be excellent components of a Neighborhood Networks center. Centers can develop elements of these programs, again in collaboration with health care partners.

Neighborhood Networks centers have a unique opportunity to significantly improve the health of residents. The ability to locate services where people

live can make a huge difference in increasing residents' access to health information and services. This is particularly powerful when relationships develop between the residents and regularly available health care professionals, especially nurses. A nurse can play two extremely significant roles: develop a relationship of trust with residents so that prevention and treatment are sought; and assist residents in navigating the increasingly complex health care world to obtain access to appropriate care.

Role of the Property and Center Staff

Staff members of the property and the Neighborhood Networks center do not need to become experts in health care. Their role embraces these important responsibilities:

- ☐ Developing partnerships with health care organizations.
- ☐ Involving residents in planning health care activities.
- ☐ Serving as liaison between health care partners and residents.
- ☐ Making appropriate space available for health care activities.
- ☐ Ensuring that health care activities are coordinated with other center activities.
- ☐ Collaborating with health care partners in obtaining additional funding and resources.

In this capacity, staff can enhance the benefits to residents of the Neighborhood Networks center and maximize access to health care and health care information by center participants.

Resident Involvement is Critical

As with all components of Neighborhood Networks centers, resident involvement is critical to the success of health care activities. Each center can involve residents in particular ways, depending on the characteristics of the center and property. Some important ways to involve residents in the health care component are:

- ☐ Include residents in initial discussions about creating the health care component and in subsequent planning groups.
- ☐ Assess resident health care needs, perhaps through a survey or focus groups.
- ☐ Conduct outreach to the local community to encourage participation in health care activities.
- ☐ Recruit residents to monitor health care programs of the Neighborhood Networks center and provide feedback on health care activities.

Selecting Services

The health care needs of different communities vary depending on the residents of the community and the existing health care resources. The process for establishing what services would be useful to a particular group of people is called a needs assessment. The needs assessment establishes the information and services that are needed and would be utilized.

It may be advisable to have your health care partner conduct the needs assessment. Your health care partner has the knowledge and expertise that will allow them to effectively gather and analyze information. Additionally, this resolves any privacy issues that may be of concern. Your health care partner's involvement at the beginning stages of planning health care activities will increase their sense of ownership of the activities.

There are two components of a needs assessment. The first is objective information regarding the health needs of a community. The second is resident-perceived needs.

Objective information about the health needs of a particular community can be obtained from statistical information about the community from government sources, such as the local health department. Health assessments of community residents are another source of objective information. This information establishes a baseline of health for the community. All the programs providing on-site health services (West End, Duquesne University, MFI and Golden West) objectively assessed residents' health. West End performed door-to-door health assessments at chosen sites prior to the start of the program. Duquesne University performed health examinations at one site but conducted chart audits at another. MFI based the decision of which services to offer initially on their experience at another property with similar demographics, but since opening have concentrated on performing comprehensive health assessments. The Golden West Director of Resident Services performs a pre-admission assessment of a resident's health. The baseline health information is not always easy to obtain before the opening of a program, so staff must remain flexible to make changes in services provided as needs are identified.

Ongoing communication with residents is the source of information about resident-perceived needs. Before the start of a program, focus groups may be warranted. Giving program staff high visibility at community events may encourage resident opinions of the planned activities. Resident feedback is essential at the start of the program and throughout the program's life.

Types of Health Care Programs

Numerous Neighborhood Networks centers have health care programs at their properties. Those programs fall into four main categories. The models in this guide also illustrate these four types of programming:

- ☐ **On-site Health Care Services** – Some properties have arranged for physicians and/or nurses to conduct on-site medical assessments, case management and wellness programs through partnerships with schools of nursing, local hospitals and private practitioners and health care companies.

- ❑ **Wellness: Health Information and Health Screenings** – Many properties provide residents with health information and health screenings. For example, some senior properties have screened residents for hypertension, hearing and vision loss. Some family properties provide residents with information on child immunization, substance abuse and teen parenting. Centers offer these services in partnership with local health departments, Area Agencies on Aging, chapters of disease-specific organizations, community health centers and local hospitals.
- ❑ **Patient Advocacy** – As the Medicaid population has shifted into managed care, Neighborhood Networks centers and their health care partners are helping residents successfully navigate their health plans and providers. Center training programs teach residents how to become more responsible for their own health care. Neighborhood Networks centers are also helping enroll children in the Children's Health Insurance Program (CHIP), which is open to families who earn too much to qualify them for Medicaid.
- ❑ **Telehealth** — Many centers are using the Internet to access health care information on a range of topics including diabetes, asthma and Medicare. Some centers have joined online disease support groups and formed on-site groups to address residents' health concerns.

Benefits to Health Care Partners

One of the most critical aspects of developing on-site health care is the establishment of partnerships with appropriate organizations.

When looking for partners, it is important to identify the potential partner's mission. Entities that have similar missions, such as those wanting to serve low-income persons, or symbiotic missions, such as a need for large training sites, are good candidates for partnership. Developing a successful partnership requires knowing an organization's mission as well as its decision-makers. It may be necessary to convince them of the mutual benefits of partnering.

Neighborhood Networks centers offer health care partners key resources and benefits, such as:

- ❑ **Access to a medically underserved community right where the residents live.** The on-site location overcomes barriers to accessing health care, such as child care and transportation. Partners meet their goals of increasing availability and the use of their services by low-income persons.
- ❑ **Improved relations with the community and positive public perception.** A positive public opinion has many benefits. It can potentially attract customers for other services.
- ❑ **Strengthened grant applications.** Funders want to see linkages with community-based groups, such as Neighborhood Networks centers, as well as innovative approaches, such as housing-based services and telehealth.
- ❑ **Space at the housing development.** For partner organizations, an office for individual consultations, as well as meeting rooms for education and information sessions that a Neighborhood Networks center can offer, are often hard to come by.
- ❑ **Computer resource centers with Internet access.** Technology is expensive and not always widely available at partner organizations.
- ❑ **Neighborhood Networks center professional staff.** Center staff who have positive relationships with the resident community and its leaders can provide a key link for outreach.
- ❑ **Computer-trained residents.** Partners can work with residents who are already comfortable with the technology.

Key Health Care Partners

Several types of organizations lend themselves as potential Neighborhood Networks center partners. These include university-based programs, such as schools of nursing and public health, state and local

health departments, hospitals, community health centers, Special Supplemental Nutrition Program for Women, Infants and Children (WIC) sites, Area Agencies on Aging and home health agencies.

Schools of Nursing and of Public Health

To fulfill their requirements, most nursing and public health students must have supervised, practical experience in the community. Neighborhood Networks centers can provide an excellent training ground for students to gain experience in working with people from diverse racial, ethnic and economic groups. Community nursing is an increasingly important discipline, and home health care is an expanding field. Public health students may focus on such concerns as nutrition, drugs and alcohol, sexually transmitted diseases or maternal and child health.

State and Local Health Departments

The basic focus of state and local health departments is on preventive and protective health and health promotion. The purpose of health promotion activities is to inform, educate and empower people. Health departments mobilize community partnerships to identify and solve health problems. They focus on improving access to services needed by the medically underserved.

Hospitals

Hospitals are increasingly interested in balancing their traditional emphasis on illness with activities that focus on prevention and education and decreasing reliance on emergency rooms for non-emergency needs. They are also interested in improving relations with the communities in which they are located.

Community Health Centers

Community health centers provide access to case-managed, family-oriented, culturally-sensitive preventive and primary health care services for people living in rural and urban medically-underserved communities. Their services are prevention oriented and include such children's services as immunizations, well baby care and

developmental screenings. Many centers provide health education, nutrition and counseling services. Case management — the coordination of the center's services with community services appropriate to the social, medical and economic needs of the patient — is emphasized.

Special Supplemental Nutrition Program for Women, Infants and Children

The Special Supplemental Nutrition Program for Women, Infants and Children, known as WIC, provides supplemental food, health care referrals and nutrition education for low-income pregnant and postpartum women and to infants and children up to age five who are identified at nutritional risk. WIC recipients access these services at WIC sites.

Area Agencies on Aging

Area Agencies on Aging coordinate low-cost, comprehensive quality care to millions of elderly people nationwide by helping older persons and their families navigate the complex systems of community services.

Home Health Agencies

As the health care system de-emphasizes institutionalization and as seniors live longer and more independently, there is a greater role for companies providing home health services. Building a clientele through efforts that provide good marketing opportunities may interest a home health agency.

Ensuring Success

To develop the health care component of your Neighborhood Networks center, don't forget to:

- ☐ Discuss the idea with all stakeholders: residents, resident leaders, center staff, management and owner representatives.
- ☐ Contact other Neighborhood Networks centers that have a health care component and learn from them.
- ☐ Identify potential health care partners in your community.

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- ☐ Meet with potential partners to discuss possible health care activities at your center.

By taking these steps, your Neighborhood Networks center will be well on its way to providing residents with some of the basic services that can address important community needs.

Chapter 5

Resources

This section provides important resources on how to establish a health care component of your Neighborhood Networks center. Resources are organized by the types of models featured in this document. These resources represent a sample of those available. The Neighborhood Networks website (www.neighborhoodnetworks.org) lists additional resources.

On-Site Nurse and Addictions Counselor Model (Multi-Family Initiatives)

Local health departments. Information about local health departments can be obtained from the American Public Health Association at www.apha.org/secapcauc/affiliates/basic.html

American Hospital Association (AHA). AHA is the national trade association of hospitals and health care networks Website is www.aha.org.

National Association of Public Hospitals and Health Systems (NAPH). NAPH represents more than 100 hospitals and health systems which comprise the essential infrastructure of many of America's metropolitan health systems. These systems provide almost 90 percent of their services to Medicare, Medicaid and low-income uninsured patients. Often, they have clinics located in the community. Website is www.naph.org.

Also see Community Health Center and University models.

Service Coordinator Model (Golden West Senior Residence Wellness Program)

A How-To Guide: Service Coordination, Elderly Persons and People with Disabilities. This manual

provides excellent information on the role of service coordinators, including practical steps in Getting Started, Community Building, Working with Partners and Bringing More Resources into the Development. It is available from HUD's Multi-Family Housing Clearinghouse at 1-800-MULTI70. Check with your local HUD office to see if your property qualifies for grants or can use project funds for a service coordinator.

University School of Nursing and Public Health Model (Duquesne University)

American Association of Colleges of Nursing (AACN). AACN is the national voice for America's baccalaureate and higher degree nursing education programs. The membership list of 562 schools of nursing is located at website www.aacn.nche.edu/

Association of Schools of Public Health (ASPH). ASPH is the national organization that represents schools of public health throughout the country. Website: www.asph.org.

National Black Nurses Association. This 25-year-old professional nursing association seeks to improve the health status of African Americans. It has implemented hundreds of community-based programs. Health screening, promotion and education activities of community-based programs focus on a variety of issues. Prevention of cardiovascular disease and infant mortality, the early detection of cancer and strategies to reduce violence and substance abuse are examples. Website: www.bronzeville.com/nbna/index.html.

Community Campus Partnership for Health. Based at the Center for Health Professions at the University of California, San Francisco, this nonprofit organization was founded in 1996 to foster health-promoting partnerships between communities and

educational institutions. Website:
<http://futurehealth.ucsf.edu/ccph.html>.

Coalition for Healthier Cities and Communities.

This 10-year-old nonprofit organization is affiliated with the National Civic League. The coalition is a partnership of entities from the public, private and nonprofit sectors to focus attention and resources on improving the health and quality of life of communities through community-based development. A primary focus is to promote the initiation, development and sustainability of initiatives that result in healthy people and healthy communities. Website:
www.healthycommunities.org.

Community Health Center Model (West End Medical Center)

National Association of Community Health Centers (NACHC). NACHC is a membership organization representing the nation's network of frontline community health care centers. Its mission is to promote high-quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent and community directed for all medically underserved populations. Website:
www.nachc.com.

Bureau of Primary Health Care. This federal agency provides significant funding and oversight to community health centers nationwide. Website:
www.bphc.hrsa.dhhs.gov/chc/chc1.htm.

Health Benefits Counseling Model (ABC for Health Inc.)

Families USA. Families USA, a national, nonpartisan nonprofit organization dedicated to the achievement of high-quality, affordable health and long-term care for all Americans, has given health care consumers a voice through its national advocacy. Members who advocate on behalf of patients are located throughout the country. Website: www.familiesusa.org/.

Health Care Financing Administration (HCFA).

This federal agency manages Medicare, Medicaid and the Children's Health Insurance Program (CHIP). It has insurance counseling staff in each state to provide information about HCFA programs. HCFA's

website is located at www.hcfa.gov. Comparisons between each state's Medicare-managed care plans are provided at www.medicare.gov/comparison/.

Children's Defense Fund (CDF). The mission of this private, nonprofit organization is to educate the nation about the needs of children. It promotes preventive investments in children before they get sick, drop out of school, suffer family breakdown or get into trouble. Website: www.childrensdefense.org/.

American Association of Retired Persons (AARP).

A nonprofit, nonpartisan advocacy organization, AARP is dedicated to helping older Americans achieve independence and live with dignity and purpose. Website: www.aarp.org.

Telehealth Model (Michigan Interactive Kiosk)

Telecommunications and Information Infrastructure Assistance Program. The U.S. Department of Commerce is a funding source for advanced technology projects, including telehealth and telemedicine. The program is called the Telecommunications and Information Infrastructure Assistance Program (TIIAP). It provides matching grants to nonprofit organizations, such as schools, libraries and hospitals; public safety entities and state and local governments. Grants fund projects that improve the quality of and the access to health care, education, public safety and other community-based services. The website (www.ntia.doc.gov/otiahome/tiiap/index.html) contains information about the grant funding process, lists the recipients of past grants and provides information about grantee projects.

Federal Telehealth Funding Guide. This website (www.nal.usda.gov/orhp/teleheal.htm) provides information and contacts for telehealth and telemedicine funding from federal agencies, including the National Library of Medicine, Rural Utilities Service, Office of Rural Health Policy, National Cancer Institute and National Science Foundation.

California Telehealth and Telemedicine Center.

The center's mission is to improve and expand telehealth and telemedicine programs in rural and

underserved communities. The center helps health care providers launch telehealth and telemedicine

projects to benefit these communities. Website: www.catelehealth.org.

ENDNOTES

¹ Olson, Krista and Pavetti, LaDonna. 1996. *Personal and Family Challenges to the Successful Transition from Welfare to Work*. Washington D.C: The Urban Institute

² Carol A. Taylor, Lenore Resick, Joyce D'Antonio and Theresa Carroll. *Advance Practice Nurse Quarterly*, 1997, 3(2), 36-45, The Advanced Practice Nurse Role in Implementing and Evaluating Two Nurse Managed Wellness Clinics: Lessons Learned about Structure, Process and Outcomes.